New Jersey Department of Health and Senior Services
Division of HIV/AIDS Services - HIV Home Care Program

CLIENT INTAKE RECORD

Last Name	First Name	Middle Initial

1. Name of Agency	2. Case Manager ☐ RN ☐ MSW	3. Intake Date ____/____/____ *Month / Day / Year*

4. ID Number

____ - ____ ____ ____ ____
1st Letter of Last Name + *Last 4 Digits of Social Security Number*

5a. Name of Referring Hospital/Agency

5b. Agency Type:
☐ Client   ☐ Clinic/Social Service Agency
☐ Hospital   ☐ Social Worker
☐ Physician   ☐ Friend/Family
☐ Other, Specify: _____

5c. Referral Date
____/____/____
Month / Day / Year

6. Enrollment Date
____/____/____
Month / Day / Year

7. City	8. County	9. Zip Code

10. Is client being re-enrolled into the HIV Home Care Program?
☐ Yes   ☐ No   If Yes, specify reason for re-enrollment: _____

11. Race
☐ American Indian or Alaskan Native   ☐ More than one race
☐ Asian   ☐ Unknown/Unreported
☐ Black or African American   ☐ White
☐ Native Hawaiian or Other Pacific Islander

12. Hispanic or Latino/a Ethnicity
☐ Hispanic or Latino/a
☐ Non-Hispanic or Non-Latino/a
☐ Unknown/Unreported

13. Gender
☐ Male
☐ Female
☐ Transgender
☐ Unknown/Unreported

14. Date of Birth
____/____/____
Month / Day / Year

15. Age

16. Living Arrangement
☐ Homeless/Shelter   ☐ Living Alone   ☐ Living with Spouse
☐ Living with Friend   ☐ Living with Relative(s) ☐ Living with Children-
☐ Living in Group Facility ☐ Living with Parents/Guardian   (No. of Children Under 18: _____)
☐ Other

17. Current Employment Status *(Check ALL that apply)*
☐ Employed Full Time (35 or More Hours/Week)
☐ Employed Part Time (Less Than 35 Hours/Week)
☐ Medically Disabled
☐ Not Employed

18. Number of Persons Living in Household: _____

19. Gross Monthly Household Income from ALL Sources: $_____

20. Does client have health insurance coverage?
☐ Yes   ☐ No
If No, complete Question 21
If Yes, complete the following:
☐ Private Insurance
   Specify: _____
☐ Medicare
☐ Medicaid
☐ Other
   Specify: _____

21. Has health insurance coverage been applied for?
☐ Yes   ☐ No   Date Application Sent
If Yes, complete the following: (Month/Year)
☐ SSI   ____/____
☐ SSD   ____/____
☐ ACCAP   ____/____
☐ Medicaid   ____/____
☐ Other: _____   ____/____
If No, explain: _____
When will application be
completed and mailed?   ____/____

22. Has client tested positive for HIV?
☐ Yes   ☐ No
If Yes, what is the date of the test?   ____/____
☐ Cannot recall date.   *Month/Year*

23. Has client been diagnosed with AIDS?
☐ Yes   ☐ No
If Yes, what is the date of the test?   ____/____
☐ Cannot recall date.   *Month/Year*

24a. Medical Diagnoses RELATED to HIV/AIDS:
1. _____
2. _____
3. _____

24b. Medical Diagnoses UNRELATED to HIV/AIDS:
1. _____
2. _____
3. _____

25. Exposure Category *(Check ALL that apply)*
☐ Men Who have Sex with Men (MSM)   ☐ Receipt of blood transfusion,   ☐ Undetermined/unknown/risk not
☐ Injection Drug User (IDU)   blood components or tissue   reported or identified
☐ Men Who Have Sex with Men and IDU   ☐ Heterosexual Contact   ☐ HIV Positive Mother
                                         ☐ Other   ☐ Hemophilia/Coagulation Disorder

26a. Client Needs *(Check ALL that apply)*
☐ Intravenous Therapy   ☐ Drug Education
☐ Oxygen Therapy   ☐ Drug Monitoring
☐ Other: _____

26b. Assistance With
☐ Transferring   ☐ Dressing   ☐ Toileting   ☐ Shopping   ☐ Laundry
☐ Walking   ☐ Bathing   ☐ Meal Preparation   ☐ Housekeeping
☐ Other: _____

27a. Overall Condition
☐ Good   ☐ Fair   ☐ Poor
☐ Wasting   ☐ Terminally Ill

27b. Cognitive Impairment
☐ Yes   ☐ No

28. Circle the Estimated Number of Months HIV HCP Services Will Be Required
1   2   3   4   5   6   7   8   9   10   11   12

29a. Supervisor	29b. Date